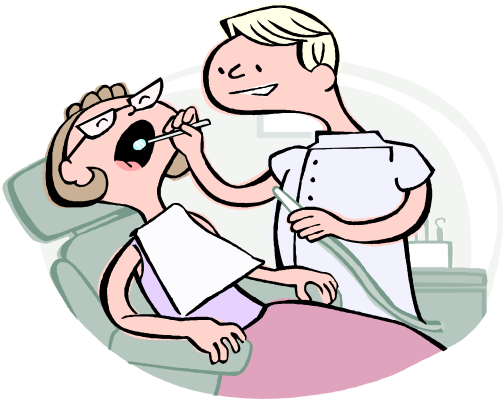
Missouri Medicaid Dental Billing Book



Missouri Department of Social Services
Division of Medical Services

Created by the Provider Education Unit

Missouri Medicaid Dental Billing Book

Preface

This Dental training booklet contains information to help you submit claims correctly. The information is only recommended for Missouri Medicaid providers and billers if your Medicaid provider number begins with 40 or 74. The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for entire content.

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SECTION 1
MEDICAID PROGRAM RESOURCES
Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

PROVIDER COMMUNICATIONS

The following phone numbers are available for Medicaid providers to call with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The (573) 635-8908 number provides an interactive voice response (IVR) system that can address recipient eligibility, last two check amounts and claim status inquiries. Providers must use a touchtone phone to access the IVR. There is no option to be transferred to the Provider Communications Unit from the IVR. See page 1.3 for more information on the IVR.

Provider Communications	(573) 751-2896
Interactive Voice Response (IVR)	(573) 635-8908

The Provider Communications Unit also processes written inquires. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK
(573) 635-3559

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Infocrossing Internet billing service.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via E-mail as follows for questions regarding enrollment applications: providerenrollment@dss.mo.gov.

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare number must be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY
(573) 751-2005
Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid recipient.

PROVIDER EDUCATION
(573) 751-6683
Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

RECIPIENT SERVICES
(800) 392-2161 or (573) 751-6527
The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MEDICAID EXCEPTIONS AND DRUG PRIOR AUTHORIZATION HOTLINE
(800) 392-8030
Providers can call this toll free number to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is (573) 522-3061; the fax line to obtain a drug prior authorization is (573) 636-6470.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with Missouri Medicaid can access the *HIPAA-EDI Companion Guide* online by going to the Division of Medical Services Web page at www.dss.mo.gov/dms and clicking on the “Providers” link at the top of the page. On the Provider Participation page, click on the HIPAA-EDI Companion Guide link in the column on the left hand side of the page. This will take you directly to the EDI Companion Guide and X12N Version 4010A1 Companion Guide links.

For information on the Missouri Medicaid Trading Partner Agreement, click on the link to Section 1- Getting Started, then select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

INTERACTIVE VOICE RESPONSE (IVR)
(573) 635-8908

The Provider Communications Unit Interactive Voice Response (IVR) system, (573) 635-8908, requires a touchtone phone. The nine-digit Medicaid provider number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 1 — Recipient Eligibility

Recipient eligibility **must** be verified **each** time a recipient presents and should be verified **prior** to the service. Eligibility information can be obtained by a recipient's Medicaid number (DCN), social security number and date of birth, or if a newborn, using the mother's Medicaid number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2 — Last Two Check Amounts

Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 — Claim Status

After entering the recipient's Medicaid number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

INTERNET SERVICES FOR MEDICAID PROVIDERS

The Division of Medical Services (DMS), in cooperation with Infocrossing Healthcare Services, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify recipient eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments;
- View claim, attachment and prior authorization (PA) status; and
- View and download public files.

The Web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the Web site services. To participate in the service, the provider must apply on-line at www.dss.mo.gov/dms. Each user is required to complete this on-line application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the www.emomed.com Web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the on-line Internet application should be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This Web site, www.emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper Web browser. The provider must have one of the following Web browsers: Internet Explorer 5.0 or higher or Netscape 4.7 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING RECIPIENT ELIGIBILITY THROUGH THE INTERNET

Providers can access Missouri Medicaid recipient eligibility files via the Web site. Functions include eligibility verification by recipient ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MEDICAID CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- 837 - Health Care Claim
  - Professional
  - Dental
  - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The Medicaid program phased out the mailing of paper Remittance Advices (RAs). Providers no longer will receive both paper and electronic RAs. If the provider or the provider's billing service currently receives an electronic RA, (either via the emomed.com Internet Web site or other method), paper copies of the RA were discontinued. All providers and billers must have Internet access to obtain the printable electronic RA via the Infocrossing Internet Service, emomed.com.

Receiving the Remittance Advice via the Internet is beneficial to the provider or biller's operation. With the new Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks earlier than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider or biller's operating system for retrieval at a later date.

The new Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services. If a provider does not have access to the Internet, contact the Infocrossing Help Desk, (573) 635-3559, to learn how to obtain a paper remittance.

ADJUSTMENTS THROUGH THE INTERNET

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 – Replacement (Adjustment) or an 8 – Void (Credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the Web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the HIPAA related claim codes and other HIPAA related codes.

MISSOURI MEDICAID PROVIDER MANUALS AND BULLETINS ON-LINE
www.dss.mo.gov/dms

Missouri Medicaid provider manuals are available on-line at the DMS Web site, www.dss.mo.gov/dms. To access the provider manuals, click on the "Providers" link at the top of the DMS home page. Scroll to the bottom of the Provider Participation page and click on the Provider Manuals link. The next page displays an alphabetical listing of all Medicaid provider manuals. To print a manual or a section of a manual, click on the Synchronize Contents link on the left hand side of the page, this will bring you to the "Print A Manual" link. Instructions for printing manuals or sections of manuals are available through this link.

Missouri Medicaid provider bulletins are also available at the DMS Web site. The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. To access the bulletins, click on the Provider Bulletin link on the Provider Participation page. The bulletins appear on-line at this location until the provider manuals are updated. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

CLAIMS PROCESSING SCHEDULE FOR STATE FISCAL YEAR 2007

Cycle Run/Remittance Date* -	Check Date -
Friday, June 23, 2006	Wednesday, July 5, 2006
Friday, July 7, 2006	Thursday, July 20, 2006
Friday, July 21, 2006	Monday, August 7, 2006
Friday, August 4, 2006	Monday, August 21, 2006
Friday, August 18, 2005	Tuesday, September 5, 2006
Friday, September 8, 2006	Wednesday, September 20, 2006
Friday, September 22, 2006	Thursday, October 5, 2006
Friday, October 6, 2006	Friday, October 20, 2006
Friday, October 20, 2006	Monday, November 6, 2006
Friday, November 3, 2006	Monday, November 20, 2006
Friday, November 17, 2006	Tuesday, December 5, 2006
Friday, December 8, 2006	Wednesday, December 20, 2006
Friday, December 22, 2006	Friday, January 5, 2007
Friday, January 5, 2007	Monday, January 22, 2007
Friday, January 19, 2007	Monday, February 5, 2007
Friday, February 9, 2007	Tuesday, February 20, 2007
Friday, February 23, 2007	Monday, March 5, 2007
Friday, March 9, 2007	Tuesday, March 20, 2007
Friday, March 23, 2007	Thursday, April 5, 2007
Friday, April 6, 2007	Friday, April 20, 2007
Friday, April 20, 2007	Tuesday, May 8, 2007
Friday, May 4, 2007	Monday, May 21, 2007
Friday, May 18, 2007	Tuesday, June 5, 2007
Friday, June 8, 2007	Wednesday, June 20, 2007

*The Cycle Run Dates are tentative dates calculated by the Division of Medical Services. The dates are subject to change without prior notification.

*All claims submitted electronically to Infocrossing, must be received by 5:00 p.m. of the Cycle Run/Remittance Advice date in order to pay on the corresponding check date.

State Holidays

July 4, 2006 Independence Day
September 4, 2006 Labor Day
October 9, 2006 Columbus Day
November 10, 2006 Veteran's Day
November 23, 2006 Thanksgiving
December 25, 2006 Christmas

January 1, 2007 New Year's Day
January 15, 2007 Martin Luther King Day
February 12, 2007 Lincoln's Birthday
February 19, 2007 Washington's Birthday
May 7, 2007 Truman's Birthday
May 28, 2007 Memorial Day

SECTION 2
ADA 2000 CLAIM FILING INSTRUCTIONS

The ADA-2000 claim form should be typed or legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5300
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at www.dss.mo.gov/dms.

NOTE: An asterisk (*) beside a field number indicates a required field. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

Field number and name		Instructions for completion
1-7		Not required.
8.*	Patient Name	Enter the patient's last name first, first name, and middle initial as shown on the patient's Medicaid card.
9.	Address	Not required.
10.	City	Not required.
11.	State	Not required.
12.	Date of Birth	Not required.
13*.	Patient ID#	Enter the Medicaid ID number as shown on the patient's Missouri Medicaid card.
14.	Sex	Not required.
15.	Phone Number	Not required.
16.	Zip Code	Not required.
17-18		Not required.

19-30**		When verifying the patient's eligibility, verify if there is other insurance coverage. If applicable, enter the name of the dental insurance, their address, and the policy number. If the other insurance pays, the amount paid should be entered in field 59, section "Payment By Other Plan". **LEAVE BLANK IF THERE IS NO OTHER DENTAL COVERAGE.** (These fields should reflect only non-Medicaid information.)
31-37**	Other Insurance	Required only if patient has a second dental policy. **LEAVE BLANK IF THERE IS NO OTHER DENTAL COVERAGE.** (This field should reflect only non-Medicaid information.)
38-41		Not required.
42.*	Name of Billing Dentist or Dental Entity	Write or type the provider's name exactly as it appears on the label.
43.	Phone Number	Not required.
44.*	Provider ID#	Write or type the provider's Missouri Medicaid number exactly as it appears on the provider label.
45.	Dentist SSN or TIN	Not required.
46.	Address	Not required.
47.	Dentist License #	Not required.
48.	First Visit Date	Not required.
49.	Place of Treatment	Not required.
50.	City	Not required.
51.	State	Not required.
52.	Zip Code	Not required.

FIELDS 42, 46, 50, 51, AND 52 MAY BE COMPLETED WITH THE USE OF THE MISSOURI MEDICAID PROVIDER LABEL.

53.**	Radiographs	Mark "yes" if x-rays accompany the claim. ***Do not*** send x-rays routinely, the State Dental Consultant will request them if needed. Refer to the Dental manual for specific procedures which require x-rays.

54-55.	Not required.
56.* Is Treatment a Result Of…	If treatment is the result of an occupational illness or injury, mark “yes” and list the date, location and cause, otherwise, mark “no”.
57.* Is Treatment a Result Of...	Mark the appropriate box. If marked “yes”, enter date and location.
58. Diagnosis Code Index	Not required.
59.* Date of Service	Enter the actual date services were rendered in month/day/year numeric format. **REMINDER: The date of service for dentures (full or partial) is the date of placement.**
* Tooth Number or Letter	Enter the appropriate tooth number or letter for services performed on each line item of the claim. If a particular tooth number or letter does not apply, leave blank. When billing for partial dentures enter the tooth number for one of the teeth being replaced in this field, then list the remaining teeth in the description field. A – T Deciduous teeth 1 – 32 Permanent teeth AS – TS Deciduous supernumerary tooth 51 – 82 Permanent supernumerary tooth Alveoplasties should be billed using tooth number 1 for upper right quadrant, 9 for upper left quadrant, 17 for lower left quadrant, and 25 for lower right quadrant.
* Surface Code	Complete this field, **if applicable.** M – Mesial D – Distal O – Occlusal L – Lingual I – Incisal F – Facial B - Buccal
Diagnosis Index #	Not required.

* Procedure Code	Enter the five digit code for the service performed, as well as any applicable modifiers.
* Quantity	The quantity will always be one (1) except for some injection codes.
** Description	Only required in specific situations as indicated in the Dental Manual.
* Fee	Enter your usual and customary fee for the procedure(s) performed.
* Total Fee	Enter the total of the charges shown.
**Payment by Other Plan	Enter the total amount received by all other insurance resources. Previous Medicaid payments, and cost-sharing, co-insurance, or copay amounts are not to be entered in this field. If the other insurance denied the claim, attach a copy of the Explanation of Benefits which denied the charges.
* Admin. Use Only	You may enter the recipient's patient account number in this field.
Maximum Allowable	Not required.
Deductible	Not required.
Carrier %	Not required.
Carrier Paid	Not required.
Patient Pays	Not required.
60. Identify the missing teeth...	Not required.
61.** Remarks	For timely filing purposes, if the claim is resubmitted after the date of service is one year old, enter the Internal Control Number (ICN) of the previous related claim, or attach a copy of the original remittance advice indicating the claim was initially submitted within one year from the date of service.
62-66	Not required.

Dental Claim Form

MISSOURI MEDICAID PROGRAM

1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name Address

38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No If no, reason for replacement: Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with "X"

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

GTE DATA SERVICES COPY

RETURN ORIGINAL TO:
GTE DATA SERVICES
P.O. BOX 5300
JEFFERSON CITY, MO 65102

SECTION 3
ADJUSTMENTS

Providers who are paid incorrectly for a claim should use the *Individual Adjustment Request* form to request an adjustment. For credits only, providers may also submit individual adjustments via the Internet. Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the changes required, addressing each change separately. Field 15 of the form may be used to provide additional information. More than one claim **cannot** be processed per *Individual Adjustment Request* form. Each adjustment request addresses one particular claim. A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

If an adjustment does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word “Tracer”. Submitting another request without indicating it as a “tracer” can further delay processing. Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Request* forms are to be submitted to the address shown on the form.

GTE Data Services

MISSOURI MEDICAID
INDIVIDUAL ADJUSTMENT REQUEST

☐ UNDERPAYMENT

☐ OVERPAYMENT

FORWARD ORIGINAL TO:

DIV. OF MEDICAL SERVICES
ADJUSTMENT UNIT
P.O. BOX 6500
JEFFERSON CITY, MO 65102

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING:

1. Claim Copy
2. Remittance Advice Copy

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE

3. INTERNAL CONTROL NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐

4. RECIPIENT MEDICAID NUMBER ☐

5. PROVIDER LABEL

6. RECIPIENT NAME _____

7. REMITTANCE ADVICE DATE _____

R.A. PAGE NUMBER _____

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

	SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8. QTY/UNITS			
9. NDC/PROCEDURE CODE			
10. SERVICE DATE(S)			
11. BILLED AMOUNT			
12. PAID AMOUNT			
13. PATIENT SURPLUS			
14. OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			
15. OTHER/REMARKS			

16. PROVIDER'S SIGNATURE _____ TITLE _____ DATE _____

MO-8810 (1-87)

SECTION 4
PRIOR AUTHORIZATION

Prior Authorization

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional Medicaid Program, expanded services are available to recipients under the age of 21 through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request must be completed and mailed to Infocrossing Healthcare Services, Inc., P.O. Box 5700, Jefferson City, MO, 65102. Providers should keep a copy of the original PA request form as the form is not returned to the provider.
- The provider performing the service must submit the PA request form. Sufficient documentation or information must be included with the request to determine the medical necessity of the service.
- PA requests are not to be submitted for services prescribed to an ineligible patient. State Consultants review for medical necessity only and do not verify a patient's eligibility.
- Expanded HCY (EPSDT) services are limited to patients under the age of 21 and are **not** reimbursed for patients 21 and over even if prior authorized.
- Payment is **not** made for services initiated before the approval date on the PA request form or after the authorization deadline. For services to continue after the expiration date of an existing PA, a new PA request **must** be completed and mailed to Infocrossing Healthcare Services.
- An approved prior authorization **does not** guarantee payment.

Whether the prior authorization is approved or denied, a disposition letter will be mailed to the provider containing all of the detail information related to the PA request. All other documentation submitted with the PA request will not be returned. Requests for changes to an approved PA must be indicated on the disposition letter and submitted to Infocrossing at the address stated above. A new PA request for changes to an approved PA should not be submitted. Denied or incomplete PA requests must be resubmitted to Infocrossing with additional documentation as needed. Providers do not have to obtain a new PA request form signed by the prescribing practitioner, but may submit a legible copy of the original PA request.

Instructions for completing the PA request form are found in Section 8 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms. Instructions are also self-contained on the back of the PA request form.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

Return to: Infocrossing Healthcare Services, Inc.
PO Box 5700
Jefferson City, MO 65102

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1.	2. NAME (LAST, FIRST, M.I.)	3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. MEDICAID NUMBER
6. PROGNOSIS	7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION
9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE.		

II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING ☐ FULL ☐ INTERPERIODIC ☐ PARTIAL	12. TYPE OF PARTIAL HCY SCREEN
13. SCREENING PROVIDER NAME	14. PROVIDER NUMBER	15. TELEPHONE NUMBER ( )

III. SERVICE INFORMATION

16. REF. NO.	17. PROCEDURE CODE	18. MODIFIERS	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	FOR STATE USE ONLY: APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)

26. ADDRESS

27. MEDICAID PROVIDER NUMBER

28. SIGNATURE | DATE

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME | 30. TELEPHONE ( )

31. ADDRESS

32. DATE DISABILITY BEGAN | 33. PERIOD OF MEDICAL NEED IN MONTHS

I certify that the information given in Sections I and III of this form is true, accurate, and complete.

34. SIGNATURE OF **PRESCRIBING PHYSICIAN/PRACTITIONER** | DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin | DATE | REVIEWED BY SIGNATURE ▶

MO 886-0858 (11-04) MO 880

INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Leave Blank
2. Recipient's Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipient's current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipient's address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipient's prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening – Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. = (Reference Number) A unique designator (1-12) identifying each separate line on the request.
17. Procedure Code – Enter the procedure code(s) for the services being requested.
18. Modifier – Enter the appropriate modifier(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter the specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. **Do not use another Prior Authorization Form.**

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid identification number.
28. Signature/Date – The provider of services should sign the request and indicate the date the form was completed. (Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner – The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.

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SECTION 5
ELIGIBILITY RESTRICTIONS

A recipient must be eligible for Medicaid on each date a service is provided in order for a provider to receive Medicaid payment for those services. This is also a requirement even when the service has been prior authorized. It is the provider's responsibility to verify a recipient's Medicaid eligibility. The following ME (medical eligibility) codes have restricted dental benefits:

55-Qualified Medicare Beneficiary (QMB): A mandatory coverage group under Medicaid providing payment for qualified individuals of deductible and coinsurance amounts for *Medicare covered services*.

58 & 59-Presumptive Eligibility (TEMP): Coverage is limited to ambulatory prenatal care services only.

80-Women's Health Services: Coverage is limited to family planning, and testing and treatment of sexually transmitted diseases (STDs).

Limited Benefit Package for Adult Categories of Assistance

Senate Bill 539 passed by the 93rd General Assembly became effective August 28, 2005. Effective September 1, 2005, adults in the following categories of assistance receiving a limited benefit package are eligible for dental care only if it is related to trauma or when the absence of dental treatment would adversely affect the recipient's preexisting medical condition.

01 Old Age Assistance (OAA)
04 Permanently and Totally Disabled (APTD)
05 Medical Assistance for Families – Adult (ADC-AD)
10 Vietnamese or Other Refugees
11 Medical Assistance – Old Age Assistance (MA-OAA)
13 Medical Assistance – Permanently and Totally Disabled (MA-PTD)
14 Nursing Care – Old Age Assistance (NC-OAA)
16 Nursing Care – Permanently and Totally Disabled (NC-PTD)
19 Cuban Refugee
21 Haitian Refugee
24 Russian Jew
26 Ethiopian Refugee
83 Presumptive Eligibility – Breast or Cervical Cancer Treatment (BCCT)
84 Regular Benefit – Breast or Cervical Cancer Treatment (BCCT)

Dental services for individuals in the above categories of assistance may be provided if the dental care is related to:

- Traumatic injury of jaw, mouth, teeth or other contiguous (adjoining) sites (above the neck)
- Medical condition related to or for a:
  - Transplant recipient
  - Chemo/radiation therapy recipient
  - Systemic diseases
    - AIDS
    - Other autoimmune diseases
      - Uncontrolled diabetics
      - Paraplegic
      - Quadraplegic
      - Any other medical condition if left untreated, the dental problems would adversely affect the health of the individual resulting in a higher level of care.

Medicaid eligible adults in the assistance categories for pregnant women or the blind and vendor nursing facility residents continue to receive the full comprehensive benefit package.

Additional information regarding the limitations and restrictions for the above categories of assistance can be found in Sections 1 and 13 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms.

SECTION 6
COPAYMENT – COINSURANCE

Providers of service are responsible for collecting copayment and coinsurance amounts from recipients, unless otherwise exempt. The provider shall collect copayment or coinsurance from the recipient at the time each service is provided or at a later date. Providers may not deny or reduce services to recipients, otherwise eligible for benefits, solely on the basis of the recipient's inability to pay. Whether or not the recipient is able to pay the required amount at the time the service is rendered, the amount is a legal debt and is due and payable to the provider of service. The Medicaid program shall not increase its reimbursement to a provider to offset any uncollected copayment or coinsurance from a recipient.

Copayment

The following copayment amounts are applied to *dental* services; CPT or surgical procedures are not subject to copayment. The amount of copayment to be collected from the recipient is based on the Medicaid reimbursement amount per date of service or item as listed on the following schedule:

Medicaid Reimbursement for Each Item	Recipient Copayment
$10.00 or less	$ .50
$10.01 - $25.00	$ 1.00
$25.01 - $50.00	$ 2.00
$50.01 or more	$ 3.00

Exemptions to Copayment

- Recipients under the age of 19 or receiving Medicaid with ME codes 06, 33, 34, 36, 40, 52, 56, 57, 60, 62, 64, 65, 71, 72, 73, 74, 75, 87 and 88;
- Foster Care recipients under the age of 21 receiving Medicaid with ME codes 07, 08, 28, 29, 30, 37, 49, 50, 51, 63, 66, 67, 68, 69 and 70;
- Recipients receiving Medicaid services for the blind under ME codes 02, 03, 12 and 15;
- Recipients receiving Medicaid services for pregnant women under ME codes 18, 43, 44, 45, 58, 59 and 61;
- Services provided to MC+ Managed Care enrollees;
- Recipients residing in a skilled nursing facility, an intermediate care nursing facility, a residential care home, an adult boarding home or a psychiatric hospital; or recipients receiving Medicaid under ME codes 23 and 41;
- When coinsurance is charged for dentures

Denture Coinsurance

The coinsurance amount applies to each interim, partial and full denture unless one of the following exceptions apply. The amount collected from the recipient is 5% of the lesser of Medicaid's maximum allowable amount or the provider's billed charge.

- Recipients under the age of 19;
- Foster Care recipients under the age of 21
- Recipients residing in a skilled nursing facility, psychiatric hospital, residential care facility or an adult boarding home; and
- MC+ health care plan enrollees for services provided by the plan.

Procedure Code	Medicaid Maximum Allowable
D5110	$ 357.00
D5120	$ 355.00
D5130	$ 361.00
D5140	$ 360.00
D5211	$ 272.00
D5212	$ 276.00
D5213	$ 385.00
D5214	$ 386.00
D5820	$ 286.00
D5821	$ 286.00
D5860	$ 457.50
D5861	$ 457.00

NOTE: Denture procedure codes D5110 through D5821 are a covered service for recipients under the age of 21 or under a category of assistance for pregnant women, the blind or vendor nursing facility residents. Procedure codes D5860 and D5861 require an approved prior authorization and are restricted to recipients under the age of 21.

SECTION 7
BENEFITS & LIMITATIONS

Office Visit Limitations

An office visit includes, but is not limited to, the following:

- Oral examination of the recipient for symptoms or indications of a dental condition requiring treatment;
- Establishment of the written recipient record;
- Surgical gloves, drapes, tongue depressors, swabs, gauze, medications, administration of injection(s) and any other items or supplies considered to be routine to the dentist's private practice; and
- Local anesthesia.

Office visits are limited to one visit per recipient per provider on any given day and may not be billed on the same date of service as another office or outpatient visit, dental screen, subsequent hospital visit, consultation or nursing home visit. An office visit may be billed on the same date of service as a hospital admission.

Procedure codes 99201-99332 cannot be billed on the same date of service as procedure codes D0120-D0170 and D9310-D9440.

"New Recipient" office visits are limited to one per provider for each recipient when dental services have not been received in the past two years.

Billing for an office visit is expected *only* for the first session in a series of treatments.

Providers cannot bill a recipient for missed/broken appointments, nor can the Division of Medical Services (DMS) reimburse providers for missed/broken appointments.

Preventative

Prophylaxis of either the upper or lower arch or both arches is covered once in a six-month period. ***If a prophylaxis is required more often than every six months, a provider may bill under procedure code D9999 and attach office notes to the claim form explaining the medical necessity***. Prophylaxis must include scaling and polishing of teeth unless scaling is not required for the individual (usually a child) based on the condition at the time of the appointment. The recipient's record must document scaling was not required during the visit.

D1110 – Ages 13-125
D1120 – Ages 0-12

Fluoride treatment is limited to one application of stannous fluoride or acid-phosphate fluoride in six-month intervals. Each allowable fluoride treatment must include both the upper and lower arch. Fluoride treatments are covered for recipients under the age of 21.

D1201 – Includes the prophylaxis
D1203 – Prophylaxis not included

Fluoride treatments for recipients 21 and over, D1204, is limited to the following criteria:

- Recipients with rampant or severe caries (decay);
- Recipients who are undergoing radiation therapy to the head and neck;
- Recipients with diminished salivary flow;
- Mentally retarded individuals who cannot perform their own hygiene maintenance; or
- Recipients with cemental or root surface caries secondary to gingival recession.

Sodium fluoride series treatments are *not* covered.

Dental sealants are covered for recipients age 5 through 20. Sealants may be applied only on healthy first and second permanent molars which have not had the occlusal surface restored. Valid tooth numbers are 2, 3, 14, 15, 18, 19, 30 and 31. Payment for each tooth is a once in a lifetime fee. No payment is made for sealants applied to third molars.

Periodontal Scaling and Root Planing – D4341

Procedure code D4341 requires an approved prior authorization (PA). Along with the PA request, providers must submit a pretreatment x-ray (a full mouth survey taken within the last 12 months) and a periodontal chart. The following guidelines are used to determine medical necessity for approval of the PA request. Approval, if given, is per quadrant:

- Verifiable signs of early or moderate chronic periodontia;
- Records must show two or more sites in the quadrant being treated with;
    1) probing depths of 5mm or greater; ***and***
    2) early to moderate bone loss, ***or***
    3) radiographic evidence of subginvgival calculus.

Definition of bone loss:

- Early bone loss is cratering, or horizontal or vertical loss.
- Moderate bone loss is notable bone loss with 50% of the root remaining in the bone.

Restorations

- The same restoration on the same tooth in less than a six-moth period is not allowed.
- Amalgam restorations include polishing, local anesthesia, liner and treatment base.
- Resin restorations include local anesthesia, liner and treatment base.
- When billing for any of the amalgam, composite or resin restorations, the tooth number and tooth surface code(s) must be entered on the claim.
- Amalgam and resin restorations on posterior teeth are covered; resin restorations are covered on *anterior* teeth.

Crowns

- Prefabricated stainless steel crowns (D2930 and D2931) and prefabricated stainless steel crowns with resin window (D2933) for primary and permanent teeth are covered for recipients of all ages; replacement within six months is not covered.
- Prefabricated resin crowns are covered for recipients of all ages for *anterior* teeth only; replacement within six months is not covered.
- The fee for fixed prefabricated crown of chrome, stainless steel, resin, stainless steel with resin window or polycarbonate includes all prior preparations.
- Porcelain crowns are covered for recipients under the age of 21 on a prior authorized basis.

Extractions

- Procedure code D7140 is the appropriate code for all non-surgical extractions of erupted teeth, permanent and primary. The appropriate tooth number must be shown on the claim.
- Surgical removal of erupted teeth, D7210, is covered for permanent teeth only.
- The surgical removal of impacted teeth, D7220-D7241, is a covered service. A paper claim must be submitted for the removal of impacted teeth other than third molars and must include pre-treatment x-rays.
- The surgical removal of residual tooth roots (cutting procedure), D2750, is covered but cannot be billed on the same date of service as an extraction of the same tooth. Pre-treatment x-rays and office notes or operative report must be sent with the claim.
- Extraction fees for routine and impacted teeth include the fee for local anesthesia and post-operative treatment.

Dental Services/Care for Adults with a Limited Benefit Package

The following procedure code lists apply to Medicaid eligible adult recipients receiving a limited benefit package as a result of Senate Bill 539.

Procedure Code List "A"

The following codes are for services related to trauma or a medical condition.

10060	15261	21070*	21242	21400*	40500
10061	17000	21079	21243	21401*	40510
10120	17280	21080	21244	21406	40520
10121	17281	21081	21245	21407	40530
11044	17282	21082	21246	21408	40650
11100	17283	21083	21247	21421	40800
11101	20000	21084	21248	21422	40801
11440	20005	21085	21249	21423	40804
11441	20200	21086	21255	21431	40805
11442	20205	21087	21256	21432	40806
11443	20206	21088	21270	21433	40808
11444	20220	21089	21275	21435	40810
11446	20225	21120	21295	21436	40812
11640	20240	21121	21296	21440	40814
11641	20245	21122	21299	21445	40816
11642	20520	21123	21300	21450	40818
11643	20525	21125	21310	21451	40819
11644	20605	21127	21315	21452	40820
11646	20650	21141	21320	21453	40830
12011	20670	21142	21325	21454	40831
12013	20680	21143	21330	21461	40840
12014	20690	21145	21335	21462	40842
12015	20692	21146	21336	21465	40843
12051	20693	21147	21337	21470	40844
12052	20694	21150	21338	21480	40845
12053	20900	21151	21339	21485	40899
13131	20902	21154	21340	21490	41000
13132	20910	21155	21343	21493	41005
13133	20926	21159	21344	21494	41006
13150	21010*	21160	21345	21495	41007
13151	21015	21193	21346	21497	41008
13152	21025	21194	21347	21499	41009
13153	21026	21195	21348	29800	41010
14040	21029	21196	21355	29804	41015
14041	21030	21198	21356	30580	41016
14060	21031	21206	21360	30600	41017
14061	21032	21208	21365	31020*	41018
14300	21034	21209	21366	31030*	41100
15000	21040	21210	21385	31032*	41105
15120	21044	21215	21386	31600	41108
15240	21045	21230	21387	31603	41110
15241	21050*	21235	21390	31605	41112
15260	21060*	21240*	21395	40490	41113

Procedure Code List “A” (continued).

41115	42260	64736	99332	D5999	D7670
41116	42280	64738	99342	D6010	D7671
41120	42281	64740	99343	D6040	D7680
41130	42299	64795	D0140	D6050	D7710
41150	42300	99050	D0150	D6090	D7720
41153	42305	99058	D0160	D6095	D7730
41250	42310	99201	D0170	D6100	D7740
41251	42320	99202	D0210	D7260	D7750
41252	42325	99203	D0220	D7261	D7760
41500	42326	99204	D0230	D7270	D7770
41510	42330	99205	D0240	D7285	D7771
41520	42335	99211	D0250	D7286	D7780
41599	42340	99212	D0260	D7340	D7810
41800	42400	99213	D0270	D7350	D7820
41805	42405	99214	D0272	D7410	D7830
41806	42408	99215	D0274	D7411	D7840
41821	42409	99221	D0277	D7412	D7850
41822	42410	99222	D0290	D7413	D7860
41825	42415	99223	D0310	D7414	D7865
41826	42420	99231	D0330	D7415	D7870
41827	42425	99232	D4240	D7440	D7871
41828	42426	99233	D4241	D7441	D7872
41899	42440	99241	D4341	D7450	D7873
42000	42450	99242	D4342	D7451	D7874
42100	42500	99244	D4920	D7460	D7875
42104	42505	99245	D5913	D7461	D7876
42106	42507	99251	D5914	D7471	D7877
42107	42508	99252	D5919	D7472	D7880
42120	42509	99261	D5922	D7473	D7910
42140	42510	99262	D5926	D7485	D7911
42145	42550	99281	D5927	D7490	D7912
42160	42600	99282	D5932	D7510	D7920
42180	42650	99283	D5934	D7520	D7940
42182	42660	99284	D5935	D7530	D7941
42200	42665	99301	D5936	D7540	D7943
42205	42699	99302	D5952	D7550	D7944
42210	42700	99303	D5953	D7560	D7945
42215	42720	99311	D5954	D7610	D7946
42220	42725	99312	D5955	D7620	D7947
42225	42800	99313	D5958	D7630	D7948
42226	64600	99321	D5959	D7640	D7949
42227	64732	99322	D5960	D7650	D7950
42235	64734	99331	D5988	D7660	D7953

Procedure Code List "A" (continued)

D7955	D7980	D7991	D9212	D9242	D9440
D7960	D7981	D7995	D9220	D9248	D9951
D7970	D7982	D7996	D9221	D9310	41114
D7971	D7983	D7997	D9230	D9410	
D7972	D7990	D7999	D9241	D9420	

*These procedures can be performed bilaterally and billed with the "50" modifier.

Procedure Code List "B"

The following codes are considered support codes and are only billable in conjunction with a trauma or medical code on list "A". These dental codes are only billable for adults when provided with services to treat trauma or when the absence of dental treatment would adversely affect the recipient's preexisting medical condidition.

D0999	D2915	D3220	D3425	D4381	J0550
D1110	D2920	D3221	D3426	D4910	J0560
D1204	D2930	D3230	D3430	D4999	J0570
D2140	D2931	D3240	D3450	D5899	J0580
D2150	D2932	D3310	D3910	D6930	J0692
D2160	D2933	D3320	D3999	D6999	J0702
D2161	D2934	D3330	D4210	D7111	J0704
D2330	D2940	D3331	D4211	D7140	J1100
D2331	D2950	D3332	D4240	D7210	J1720
D2332	D2951	D3333	D4245	D7220	J2175
D2335	D2952	D3346	D4260	D7230	J2250
D2390	D2953	D3347	D4261	D7240	J2270
D2391	D2954	D3348	D4265	D7241	J2510
D2392	D2955	D3351	D4275	D7250	J2550
D2393	D2957	D3352	D4276	J0120	J3000
D2394	D2999	D3353	D4320	J0290	J3070
D2799	D3110	D3410	D4321	J0530	J3360
D2910	D3120	D3421	D4355	J0540	J3410

The recipient record must include documentation to substantiate services billed are related to trauma or other medical condition and must be provided to the state upon request.

Please refer to Section 13 of the Medicaid *Dental Provider's Manual* and the Dental Appendix for comprehensive coverage of dental benefits and limitations, as well as covered procedure codes, available on the Internet at www.dss.mo.gov/dms.

SECTION 8
DENTURES

Dentures must be dispensed to the recipient before the provider bills Medicaid; the date of service for dentures is the date of placement. Holding dentures until Medicaid payment is received constitutes payment for services not provided and is in violation of State Regulation 13 CSR 70-3.030(2)(A)23. Providers may not request or accept a deposit from a Medicaid recipient and then refund it after payment is received from Medicaid. Accepting a deposit or a portion of the fee or charge is in violation of State Regulation 13 CSR 70-3.030(2)(A)9. *This does not apply to the denture coinsurance requirement.* Medicaid reimbursement for dentures includes routine visits necessary in the steps required for the denture, full or partial. This includes impressions, try-ins and adjustments for six months from the date of placement.

Prior authorization is not required for full (D5110-D5140), partial (D5211-D5214) or interim (D5820-D5821) dentures. Prior authorization is required for overdentures (D5860 & D5861), however, coverage is restricted to recipients under the age of 21.

Immediate and interim dentures are restricted to once in a lifetime.

Replacement dentures are covered in cases when dentures no longer fit properly due to:

- significant weight loss as a result of illness;
- loss of bone or tissue due to some form of neoplasm and/or surgical procedure;
- normal wear and/or deterioration resulting from use over an extended period of time.

NOTE: Replacement dentures do not require prior authorization. PA requests submitted to Infocrossing will not be approved. Dentists must use their professional judgment in determining if the recipient's denture meets the above replacement criteria. The reason for replacing the denture must be properly documented in the recipient's record.

Denture adjustments are covered, but not for the originating dentist of a new denture until six months from the date of placement. It is the responsibility of the dentist who placed the denture to assure correct fit within this period.

Rebases and Relines

One reline or rebase is allowed *during* the 12 months following placement of *immediate* dentures. The second reline or rebase is allowed 12 months following the first reline. Additional denture relining or rebasing is limited to 36 months from the date of the preceding reline or rebase.

The initial reline or rebase of a partial or replacement denture is not covered until 12 months after the placement of the denture. Additional relining or rebasing is limited to 36 months from the date of the last preceding reline or rebase.

Denture reline or rebase, where necessary, may be accomplished on the same date of service as repair of a broken denture.

Rebasing of any denture, full or partial, must include a new impression of the old denture, check bite, and full-process procedure.

Laboratory reline of any denture, full or partial, must include a new impression of the old denture, check bite, and full-process procedure.

Tissue conditioning, D5820 and D5821, is not covered for the same date of service as a reline and/or rebase.

SECTION 9
ORTHODONTICS

Orthodontic procedures are covered as expanded HCY, Healthy Children and Youth, services. Medically necessary orthodontics is available to all Medicaid eligible recipients under the age of 21. These services require prior authorization (PA) and are only approved for the most handicapping malocclusions. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables:

- Degree of mal-alignment
- Missing teeth
- Angle classification
- Overjet
- Overbite
- Openbite
- Crossbite

Comprehensive orthodontic treatment is available only for transitional mixed (dentition) or full adult dentition. Exceptions to this policy are granted only in cases of cleft palate or severe facial anomalies where early intervention is in the best interest of the recipient. Comprehensive orthodontic treatment includes, but is not limited to:

- Complete diagnostic records and a written treatment plan;
- Placement of all necessary appliances to properly treat the recipient (both removable and fixed appliances);
- Removal of all appliances at the completion of the active phase of treatment;
- Placement of retainers or necessary retention techniques;
- Adjustment of the retainers and observation of the recipient for a proper period of time (approximately 18-24 months).

Extractions are not included in the fee for the orthodontic treatment but are separately covered under the Dental Program.

Requests for orthodontic treatment are assessed by using the Handicapping Labio-Lingual Deviation (HLD) Index. When submitting a PA request, the provider must include complete orthodontic records and a written treatment plan. Providers must label the orthodontic records, which must include at a minimum, the provider's name or number and the recipient's Medicaid/MC+ ID number. If the models and/or x-rays are unusable, they are rejected and new records must be submitted prior to authorization of treatment. The PA request, along with the required records and treatment plan, must be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5700
Jefferson City, MO 65102

Upon receipt of an approved PA, the provider must verify the recipient's Medicaid eligibility prior to beginning orthodontic treatment. It is important the recipient's eligibility be verified each time a treatment/service is rendered. The approved PA will state the length of treatment authorized, i.e., 24 months, as well as the total dollar amount authorized for the duration of the treatment.

Payment for the initial phase of a comprehensive orthodontic treatment program may occur after the initial banding has been completed. The initial fee is based on one-fourth of the total approved amount. This fee includes the orthodontic examination, preparation of the necessary dental records, determining the diagnosis, a written treatment plan and placement of appliances. The date of service for the initial payment is the date of banding.

Providers must bill subsequent payments on a quarterly basis. The amount of the quarterly payment is determined by the balance due after the initial payment has been deducted from the prior authorized amount. The remainder is divided by the total number of months treatment was authorized, and the result multiplied by three. This dollar amount represents the amount of all future quarterly payments with the date of service being the last day of the month of each quarter following banding.

Example:
Provider is authorized $2,000.00 for a 24-month treatment plan. The recipient is banded on October 26, 2003. The initial claim will be submitted with a date of service of 10/26/03 and a dollar amount of $500.00. To determine the date of the first quarterly payment, the month the recipient was banded is counted as month one, therefore, the date of service for the first quarterly payment in this example is 12/31/03. The quarterly payment amount to be billed is $187.50: $1,500.00 divided by 24 = $62.50; $62.50 x 3 = $187.50. The date of service for the second quarterly payment is 03/31/04; the third, 06/30/04; the fourth, 09/30/04, etc. The quarterly payment billed remains the same.

If a recipient is only eligible for one or two months of the quarter, the provider must bill the exact dates the recipient was seen in the office. Each month must be billed on a separate line and the allowed amount for each month is one-third of the quarterly payment.

If the recipient's eligibility ends prior to the last day of the quarter, but after the recipient is seen in the third month of the quarter, the last date of eligibility during the third month of the quarter is the date of service.

SECTION 10
CUSTOM-MADE ITEMS

Medicaid provider payment may be made for custom-made items such as dentures when a recipient becomes ineligible (either through complete loss of Medicaid eligibility or change of assistance category to one for which the particular service is not covered) or dies after the item is ordered or fabricated and prior to the date of delivery or placement of the item.

The following prerequisites apply to all such payments:

- The recipient must have been eligible when the service was first initiated (and following receipt of an approved PA request form if required) and at the time of any subsequent service, preparatory and prior to the actual ordering or fabrication of the device or item;
- The custom-made device or item must have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for a medical purpose by any other individual;
- The custom-made device or item must have been delivered or placed if the recipient is living;
- The provider must have entered “See Attachment” in the “Remarks” section of the dental claim form (field #61) and must have attached a provider signed statement to the claim. The statement must explain the circumstances and include the date of actual delivery or placement for a living recipient or the date of death when delivery or placement is not possible due to this reason. The statement must also include the total amount of salvage value, if any, which the provider estimates is represented in cases where delivery or placement is not possible.

Payments regarding the aforementioned devices are made as follows:

a. If the item is received by the recipient following loss of Medicaid eligibility or eligibility for the service, the payment is the lesser of the billed charge or the Medicaid maximum allowable for the total service, less any applicable coinsurance and any payments made by another insurance company.
b. If the item cannot be delivered or placed due to death of the recipient, the payment is the lesser of the “net billed charge” or the Medicaid maximum allowable for the total service, less any applicable coinsurance. The “net billed charge” is the provider’s usual and customary billed charge(s) as reduced by any salvage value amount.

Salvage value exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item. **Dentures are an example of an item representing no reasonable salvage value.**

The date of service that is shown on the claim form for the item (dentures) when situation a) or b) applies must be the last date on which service is provided to the eligible recipient (and following receipt of an approved PA request if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying recipient eligibility each time a service is provided. The use of a date for which the recipient is no longer eligible for Medicaid coverage of the service results in a denial of the claim. The claim (with attachment) is to be submitted to the fiscal agent (currently Infocrossing Healthcare Services) in the same manner as other claims.

Payments made as described in a) or b) constitute the allowable Medicaid payment for the service. Other than any applicable coinsurance due, no further collection from the recipient or other persons is permitted.

If the provider determines the recipient has lost eligibility after the service is first initiated and before the custom-made item is actually ordered or fabricated, the recipient must be immediately advised that completion of the work and delivery or placement of the item is not covered by Medicaid. It is then the recipient's choice whether to request completion of the work on a private payment basis. If the recipient's death is the reason for loss of eligibility, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a recipient refuses to accept the item/service, Missouri Medicaid does not reimburse the provider.

SECTION 11
RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT DENTAL TERMINOLOGY, FOURTH EDITION (CDT-4)

Missouri Medicaid currently uses the *Current Dental Terminology, fourth edition (CDT-4)*. This publication is a series of dental procedure codes used for reporting services rendered. All providers should obtain and refer to the CDT-4 to assure proper coding.

CURRENT PROCEDURE TERMINOLOGY (CPT)

Missouri Medicaid also uses the latest version of the *Current Procedural Terminology (CPT).* All providers are encouraged to obtain and refer to the CPT book to assure proper coding.

Providers can order CDT and/or CPT books from the following:

Practice Management Information Corporation
4727 Wilshire Blvd., Ste. 300
Los Angeles, CA 90010
1-800-663-7467
http://pmiconline.com

Medical Management Institute Campus Bookstore
11405 Old Roswell Road
Alpharetta, GA 30004
1-800-334-5724 ext. 1
http://www.codingbooks.com

SECTION 12
RECIPIENT LIABILITY
State Regulation 13CSR 70-4.030

If an enrolled Medicaid provider does not want to accept Missouri Medicaid as payment but instead wants the patient (recipient) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that Medicaid will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to Medicaid for reimbursement for the covered service(s).

If Medicaid denies payment for a service because all policies, rules and regulations of the Missouri Medicaid program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before Medicaid is billed.

MEDICAID RECIPIENT REIMBURSEMENT (MMR)

The Medicaid Recipient Reimbursement program (MMR) is devised to make payment to those recipients whose eligibility for Medicaid benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Recipients are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The recipient is furnished with special forms to have completed by the provider(s) of service. If Medicaid recipients have any questions, they should call (800) 392-2161.

Nondiscrimination Policy Statement

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250